September 16, 2011

Scott Wetzler, PhD.
Vice Chairman and Professor
Department of Psychiatry and Behavioral Sciences
Montefiore Medical Center
Albert Einstein College of Medicine
11 East 210th Street
Bronx, NY 10467

Dear Dr. Wetzler,

Thank you for testifying at the hearing of the Subcommittee on Human Resources of the House Committee on Ways and Means on September 8, 2011. Though I was unable to attend the hearing, the issue is of great interest to me and I look forward to engaging you in additional questions.

Given your background on substance abuse and work programs in Bronx, NY, I found particular interest in your testimony. I am interested in applying a drug testing component to Temporary Assistance for Needy Families as well as additional means-tested assistance programs, including Section 8 housing, Medicaid, and the Supplemental Nutrition Assistance Program.

In order to complete the record of the hearing, please respond to the following questions by Thursday, September 30, 2011:

1. As a result of your testimony that work requirements offer an opportunity for substance abusers to overcome addiction; is there a similar program which can be included as part of a reform to Temporary Assistance for Needy Families, and means-tested assistance at-large, which can bring testing, treatment and employment together? Specifically, at what rate of consistency of positive tests should recipients be able to return to full levels of assistance?

2. In your experience with work requirement programs, what costs do you find associated with drug-testing programs that can also be attributed to a similar program in Temporary Assistance for Needy Families?

3. How effective have you found the work requirement programs you administer to be in removing recipients from public assistance?

The Committee relies on electronic submissions for printing of the official record. Therefore, please send an electronic submission in Microsoft Word format to drew.wayne@mail.house.gov, matt.weidinger@mail.house.gov, ryan.martin@mail.house.gov and timothy.ford@mail.house.gov.

Your consideration of my additional questions is appreciated. Should you have any questions please contact Drew Wayne in my office by e-mail or at (202) 225-3161. I look forward to your response.

Sincerely,

Tom Reed
Member of Congress

Montefiore
THE UNIVERSITY HOSPITAL

EINSTEIN
Albert Einstein College of Medicine
OF YESHIVA UNIVERSITY

September 22, 2011

Rep. Tom Reed
House of Representatives
1037 Longworth House Office Building
Washington, DC 20515-3229

Dear Representative Reed,

It is my pleasure to respond to your questions related to the September 8 hearing on the re-authorization of the welfare reform legislation. As I mentioned in my prior testimony, I oversee a program in the Bronx, NY for welfare recipients with substance use disorders. Since this program began over ten years ago, we have provided clinical evaluations for 22,000 individuals with substance use disorders, determined their appropriate level of treatment, determined their capacity to participate in the work requirements, and provided case management to assist them on their path to drug abstinence and self-sufficiency.

Individuals are referred for a clinical evaluation at my program based on a generic screening conducted by the case worker at the welfare center at the time of application for benefits. Essentially, these individuals are self-identified, representing 12% of the NYC welfare population, as there is no drug testing conducted at the welfare center. It is difficult to know about the degree of substance abuse in the remaining 88% of the welfare population who do not self-identify as substance abusers.

In my opinion, drug testing represents a critical component in the treatment of substance use disorders. Substance abuse is a chronic, relapsing condition, and motivation for treatment waxes and wanes. Substance abusers are notorious for minimizing or denying the degree of their substance abuse. Thus, drug testing provides objective evidence which clinicians can and do use to corroborate or contradict the patient's self-report. In almost all treatment programs, patients are regularly and frequently tested for the presence of drugs.

In my evaluation and case management program, we limit drug testing to those individuals who deny current substance abuse and who would otherwise not be referred for treatment. If these individuals test positive, despite their denial of substance abuse, we refer them for treatment (noting the lack of insight into the need for treatment). Since individuals who acknowledge substance abuse will be referred for treatment and will receive drug tests at the treatment program in the immediate future, it is unnecessary for us to administer the drug test. Once these individuals are engaged in treatment, our case managers track their progress in treatment, including the results of ongoing drug testing.

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As I described in my prior testimony, we have found that the vast majority of substance abusers are employable and able to participate in the work requirements, as stipulated by the legislation within the time frames identified. Most substance abusers are able to meet the work participation requirements at the time of our initial evaluation, and even those individuals who are exempted from the work requirements because they require a brief period of intensive treatment, will be able to work within 4-6 weeks. In my clinical experience, work has a highly positive impact on the individual's recovery. Work should complement treatment, and I would characterize my philosophy as a "work early" if not a rigid "work first" approach.

With that as background, let me respond to each of your questions. In your first question, you ask whether individuals with positive drug tests should be able to return to full levels of assistance, both in the TANF program as well as in other means-tested assistance programs. Since substance abuse is a chronic, relapsing problem, it is often the case that these individuals will have a positive drug test after they have become engaged in treatment and even after they have completed treatment and been abstinent for a long period of time. From a clinician's vantage point, these drug test results provide important information on how to engage the individual in treatment, help the individual return to treatment, or refer the individual to a new level or kind of treatment. The NYC Human Resources Administration, our funding agency, has developed explicit treatment program standards which identify the clinical ramifications of positive drug tests at various points in time after treatment initiation. In short, if people continually test positive for substances, then they need to be moved to a different (i.e. more intensive) level of care, and if they do not comply with that mandated referral, then they will be sanctioned and lose cash assistance benefits. This is a clinical issue, not a punitive one; they need to be engaged in the appropriate level of treatment. In my view, if these individuals are being clinically evaluated and are engaged in treatment (and work, if appropriate), then they should be allowed to maintain benefits.

You also ask whether a program combining drug testing, treatment, and employment might be appropriate and effective for other means-tested assistance programs. As the cash assistance population has declined, the issue of mandated treatment (and employment) becomes even more relevant for other populations, especially the Medicaid population. In NYC, there are 8-10 times as many substance abusers on Medicaid as on cash assistance, and yet there is no oversight of their treatment. As I mentioned in my prior testimony, these individuals are enormously expensive since many do not remain engaged in outpatient substance abuse treatment. They access medical and substance abuse care in very ineffective and inefficient ways. Since many do not remain compliant with outpatient care, when they relapse, they go for inpatient detoxification, which is much more expensive. It can be a revolving door with multiple episodes of inpatient care per year. I believe that these individuals should be mandated into outpatient substance abuse treatment in order to maintain their Medicaid benefit. I further believe that case management programs, such as mine, can be very effective at helping these individuals remain engaged in outpatient treatment. Our program has demonstrated over 60% savings in substance abuse treatment costs by engaging patients in outpatient rather than inpatient treatment. Although I do not have comparable experience with the Section 8 housing or

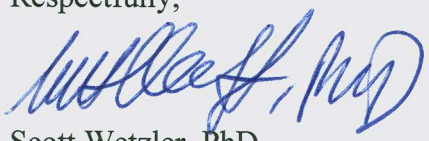
Supplemental Nutrition Assistance programs, they are generally subsumed within the Medicaid population, and individuals with substance use disorders should be engaged in the same way.

In your second question, you ask about the cost of drug testing in the context of TANF and work programs. Since I only have experience with drug testing in the context of clinical evaluations and treatment, I cannot estimate the costs of implementing drug testing on large numbers of people either in the welfare center or in an employment program. There are two kinds of drug tests: oral swabs and urines. Oral swabs are easier to administer and are easily supervised, but are more expensive. Urines are much less expensive but are more labor intensive, often involving supervised urine collection. Although it is hard to generalize to the current cash assistance population, past estimates ran as high as 37% of the welfare population testing positive for drugs (as compared with the 12% who self-identify). If you were to consider expanding drug testing to the entire cash assistance population, then you would need to anticipate the ramifications of large numbers of positive tests. In many communities, there is not sufficient treatment capacity for all of the individuals who would test positive. Furthermore, many people who would test positive do not necessarily meet diagnostic criteria for a substance use disorder and therefore would not require treatment. When an individual has a severe enough substance abuse problem such that it interferes with their work functioning, it is apparent at the employment program, at which time the individual can and should be referred for a clinical evaluation leading to mandated treatment.

In your third question, you ask about the effectiveness of my program in removing recipients from cash assistance. Although our program engages individuals with severe and longstanding substance use disorders, we have been remarkably effective at helping them obtain employment. We were the subject of a random assignment study by the social policy research firm, MDRC, and another by CASA, the Columbia University Substance Abuse Research team. They found that 37% of people in our program obtained competitive employment within 6 months, according to Unemployment Insurance data. Since many individuals obtain "off-the-books" jobs, I estimate that at least 50% of these substance abusers became employed in one way or another. This is a remarkably high figure, considering the fact that in addition to substance abuse, many of these individuals have medical and psychiatric problems, limited education, a poor work history, and criminal records. Since we monitor their transition to employment for 6 months, we can also report that they have an excellent record of job retention over that time. In addition to the 50% who obtain employment, another 5-10% of our patients are considered permanently disabled due to a medical and/or psychiatric condition (substance abuse by itself is not considered a disabling condition), and are awarded Supplementary Security Income (SSI) or Social Security Disability Insurance benefits (SSDI). Thus, 55-60% of our population exits cash assistance with financial self-sufficiency. The remaining individuals sooner or later have an administrative exit from cash assistance due to non-compliance with work or treatment requirements. Some of them cycle back onto cash assistance at a later date.

I hope these responses are helpful, and do not hesitate to contact me for further clarification.

Respectfully,



Scott Wetzler, PhD.